Reddy Medical Group

Post Office Box 529

Royston, GA 30662

877-621-7575 phone 706-621-7557 fax

AUTHORIZATION FOR RELEASE/REQUEST OF MEDICAL INFORMATION

Patient's Full Name: ______________________ Phone: ______________________

Street Address: ______________________ Email: ______________________

City/State/Zip: ______________________ Date of Birth: ______________________

Request Information From:

____
Name of Company/Agency/Facility/Person

____
Street Address

____
City/State/Zip

____
Phone / Fax

Release Information To:

____
Name of Company/Agency/Facility/Person

____
Street Address

____
City/State/Zip

____
Phone / Fax

Authorize Release of Information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment and treatment for alcohol and/or drug abuse. Yes___ No__

Information Needed For: Attorney_____ Insurance Company_____ Self_____ Other________________

Complete Record _____

Partial Record ____
(Indicate info needed and date range...for example, MRI reports 2006, Op Note from 06-13-07...etc.)

There is a fee for reproducing patient records.
These fees are pursuant to Georgia Statute§31-33-3:

*$25.88 Search and Retrieval Fee (plus per page fee below)
*$0.97 Per page for pages 1-20
*$0.83 Per page for pages 21-100
*$0.66 Per page for pages over 100
*$9.70 Certification Fee (If applicable)

This information about you is protected under federal law, and you have the right to revoke this authorization in writing. Please be advised, however that any revocation will be effective only to the extent we have not already taken action in reliance on your authorization. By signing below, you recognize that the protected health information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of this disclosure and may no longer be protected under federal law. We will not condition treatment based on your authorization. You may refuse to sign the authorization.

Signature: ______________________ Witness: ______________________ Date: ______________